Summary of Independent Review

Independent review[1] is a process for providers of TennCare services to resolve their claims payment disputes with TennCare HMOs, BHOs, and Dental Benefits Managers.[2] If a provider wishes to pursue independent review and the claims dispute is eligible, the Department of Commerce and Insurance (TDCI) will send the dispute to an independent reviewer,[3] who will decide whether the MCO correctly paid the provider. If the reviewer decides the MCO owes the provider, the MCO must pay the provider within 20 days of receipt of the reviewer's decision. If the reviewer decides the MCO correctly denied the claim, the provider must reimburse the MCO the review fee.

In place of independent review, a provider may pursue any appropriate legal or contractual remedy available.

The Independent Review Process

The Independent Review process consists of the following five steps:

1. Provider's Request for Independent Review and *Aggregation of Claims*
2. TDCI Administration
   - 2a. Eligibility Verification
   - 2b. Payment of Review Fee
     - Non-Participating vs. Participating Providers
   - 2c. TDCI's Referral of Request to Reviewer
3. Reviewer's Request for Information
4. Reviewer's Decision
5. Award

Provider's Request for Independent Review and Aggregation of Claims

Providers wishing to pursue independent review should submit the information requested on the Request for Independent Review Form to TDCI at the following address:

Independent Review Request
Compliance Officer
TennCare Division
Tennessee Department of Commerce & Insurance
500 James Robertson Parkway, Suite 750
Nashville, TN 37243

The Request Form is located at the following address:

http://www.state.tn.us/commerce/tenncare/pdf/request.pdf

A provider may also call (615) 741-2677 and request the form.

Once TDCI receives a provider's request, TDCI reviews it for eligibility. If the request is eligible, TDCI sends the request to an independent reviewer. If the request is ineligible, TDCI will notify the provider.

Aggregation of Claims

Claims involving the same MCO may be aggregated, if the specific reason for the denial involves a common question of fact or law. The mere fact that a claim is

1 T.C.A. §§ 56-32-226(b) and 71-5-2314 govern independent review.
2 MCO = TennCare HMOs, BHOs, and Dental Benefits Managers.
3 Pursuant to T.C.A. § 56-32-226(b)(4), the TennCare Claims Processing Panel selects the independent reviewers. As of October 8, 2002 there are 7 reviewers.

denied does not create a common question of fact or law. The basic rule for whether claims may be aggregated is whether a reviewer can decide for one claim and apply that decision to all claims.

For example, a transportation provider who is paid a capitated rate and disputes the number of enrollees during a specific time period may aggregate claims because the common issue among the claims is whether the MCO paid the provider the correct amount for the number of enrollees. In this example, the reviewer only needs to determine the number of enrollees and apply that fact to all the aggregated claims.

Eligibility Verification

To be eligible for Independent Review, a claim must meet ALL of the following::

1. The claim involves a TennCare service, which was provided to a TennCare enrollee,
   AND
2. The MCO:
   a. Partially or totally denied the claim in a written or electronic remittance advice; or

   b. Subsequently partially or totally denied a previously allowed claim by a written or electronic notice; or

   c. Failed to respond by issuing a remittance advice or other appropriate written or electronic notice partially or totally denying the claim within sixty(60) calendar days of the MCO's receipt of the claim.

   AND
3. The Provider sent a written request for reconsideration to the MCO
   AND
4. The MCO:
   a. Failed to respond to the request for reconsideration within 30 calendar days of the MCO's receipt of the request; or

   b. Failed to respond within 60 calendar days of receipt of the reconsideration request, if the MCO requested additional time within the first 30 calendar days of the receipt of the reconsideration request; or

   c. Failed to respond within the timeframe mutually agreed to by the provider and the MCO in writing; or

   d. Continued to deny the claim;

   AND
5. The disputed claim is not involved in arbitration or lawsuit;
   AND
6. The provider's request for independent review is made within 365 days of the MCO's first denial.

If the claim does not meet the eligibility requirements, TDCI will notify the provider.

Payment of Review Fee

The MCO initially pays all review fees for both contracted providers and providers who are not contracted with the MCO involved in the claims dispute.

Contracted Providers (Par-Providers)

The MCO initially pays the review fee. If a contracted provider loses the independent review, the contracted provider must reimburse the MCO the fee. If a losing contracted provider does not refund the MCO the fee, TDCI may prohibit that provider from future participation in the independent review process.

Non-Contracted Providers (Non-Par Providers)

Providers who do not have a contract with the MCO involved in the claims dispute must submit an amount of money equal to the review fee for TDCI to hold before the claim is eligible for review. If the non-contracted provider wins the review, TDCI will reimburse the money held to the non-contracted provider. If the MCO wins, TDCI will reimburse the MCO with the money held.

As of October 8, 2002, the review fee is $450 per claim.[4]

TDCI's Referral of Request to Reviewer

If the provider submits the information requested on the Request for Independent Review Form, meets the eligibility requirements and necessary fee obligations, then TDCI will refer the request to an independent reviewer.

If the provider has not met the various requirements, TDCI will notify the provider.

Reviewer's Request for Information

Within 14 days of receiving the request from TDCI, the reviewer will send a request for information regarding the claims payment dispute to the provider and MCO. The reviewer must receive the provider's and MCO's response within 30 days, unless the reviewer grants additional time for an aggregated claims request. The reviewer may grant the provider or MCO an additional 30 days for aggregated requests. The reviewer will not consider any information which the provider or MCO does not submit within the 30 days.

Reviewer's Decision

The reviewer shall render a decision within 60 days of the receipt of the request for independent review from TDCI, unless the reviewer requests guidance on a medical issue or requests and receives an extension of time from the Commissioner of TDCI.

The reviewer will send the provider, MCO, and TDCI a copy of the decision.

Award

If the reviewer decides the MCO should pay the provider, the MCO must pay the provider within 20 days of receipt of the reviewer's decision.

4 Pursuant to T.C.A. § 56-32-226(b)(4), the TennCare Claim Processing Panel sets the review fee. The Panel consists of two provider representatives, one representative from each of the two largest TennCare HMOs, and the Commissioner of TDCI or the commissioner's designated representative. *See* T.C.A. § 56-32-226(b)(4).